

Enhancing Home Visiting With Mental Health Consultation

abstract

Home visiting programs have been successful in engaging and enrolling families who are at high risk for stress, depression, and substance abuse. However, many of these mothers may not be receiving mental health services because home visitors lack the knowledge and skills to identify mental health or determine how to appropriately address these problems. In response, a growing number of home visiting programs are expanding their capacity by integrating a mental health provider into their ongoing operations. This approach, referred to as early childhood mental health consultation, involves a partnership between a professional consultant with early childhood mental health expertise and home visiting or family support programs, staff, and families. This integrated model holds the promise of promoting parent and child behavioral health by enhancing the capacity of home visitors to identify and appropriately address the unmet mental health needs of children and families. The article highlights efforts under way in several federally funded Linking Actions for Unmet Needs in Children's Health Project sites where local programs are testing the effectiveness of this model. *Pediatrics* 2013;132:S180–S190

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KEY WORDS

mental health consultation, home visiting, evidence-based practice, behavioral health, pediatric medical home

ABBREVIATIONS

Project LAUNCH—Linking Actions for Unmet Needs in Children's Health

SAMHSA—Substance Abuse and Mental Health Services Administration

Dr Goodson was involved in the conceptualization and design of the paper, drafted the initial manuscript, and revised the manuscript in response to reviewers' comments; Ms Mackrain and Dr Perry were involved in the conceptualization and design of the paper, drafted key sections of the manuscript, and revised the manuscript in response to reviewers' comments; Mr O'Brien was involved in the conceptualization and design of the paper, and provided data for and drafted portions of the manuscript; Ms Gwaltney was involved in the conceptualization and design of the paper, critically reviewed the manuscript, and revised the manuscript in response to reviewers' comments; and all authors approved the final manuscript as submitted.

www.pediatrics.org/cgi/doi/10.1542/peds.2013-1021S

doi:10.1542/peds.2013-1021S

Accepted for publication Aug 26, 2013

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: The US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration is the funding source for the Linking Actions for Unmet Needs in Children's Health program. Funding for the cross-site evaluation of the Linking Actions for Unmet Needs in Children's Health program is provided to Abt Associates, Inc, through a contract with the Administration for Children and Families.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

There is a growing consensus that many chronic health and developmental morbidities are the product of a complex interaction of biological, psychosocial, and environmental influences.¹ Recent discoveries in neuroscience, for example, point to the cumulative impact of adverse childhood experiences on the development of a broad range of later conditions.² Children exposed to ongoing adverse experiences can face prolonged stress, often referred to as “toxic stress,” which puts them at risk for changes in the architecture and later functioning of their brains and immune systems.³ These child risk factors may arise from dynamics in their own families, including maternal depression and clinical and social correlates of this depression: trauma and intimate partner violence, poor birth outcomes, and infant mortality.⁴ Maternal depression, often underdiagnosed and untreated in the first several years of life, is a particularly prevalent concern, with estimates ranging from 15% in the general population to double that in low-income mothers.⁵

As pediatric providers begin to incorporate the latest findings from neuroscience into their efforts to establish high-quality medical homes for their patients, they find themselves serving many families who may be at risk for toxic stress and who are experiencing psychosocial challenges. However, pediatricians and primary care providers often report not having enough knowledge to detect and manage mental health problems in young children and to make referrals for mental health prevention and treatment services.⁵

Pediatric primary care practices can take steps to care for young children with mental health problems, as well as normalizing and destigmatizing mental health, by engaging families in community services like home visitation.⁶ Home visitation programs are often designed to serve families and young children who are at heightened risk,

including families living in poverty, teenage and single parents, and families at risk for child maltreatment.

In one study of a Healthy Families America home visiting program, almost 30% of mothers enrolled screened positive for depression, and about 70% reported experiencing at least 1 violent trauma in their lives.⁷ Furthermore, although estimated rates of depression among pregnant, postpartum, and parenting mothers range from 5% to 25%,⁸ a review of studies revealed that between 28% and 61% of mothers enrolled in home visiting programs were identified with depression.⁷ Experiences of depression, substance abuse, or intimate partner violence in pregnant women have been found to contribute to low birth weight, preterm births, increased pain and discomfort during pregnancy and childbirth, and higher levels of stress.⁹

At the same time that home visiting programs appear to be reaching some of the most vulnerable families, evidence exists that home visitation programs alone may not be sufficient to address all of the mental health needs of the families they serve. A study of an initiative that implemented 4 home visiting models (Healthy Start, Healthy Families America, and 2 locally developed models) found that fewer than 25% of women with depressive symptoms received mental health services in the 6 months after enrollment in a home visiting program.¹⁰ Focus groups with home visitors suggest that training may not equip home visitors to address the mental health, substance abuse, and domestic violence in the families they serve.^{11,12}

INTEGRATION OF EARLY CHILDHOOD MENTAL HEALTH CONSULTATION AND HOME VISITING

In response to these challenges, a growing number of home visiting programs are

expanding their capacity to serve high-risk families by integrating a mental health provider into the ongoing operations of their programs. These approaches, referred to as early childhood mental health consultation, involve a partnership between a professional consultant with early childhood mental health expertise and home visiting programs, staff, and families; the models are similar to the integration of mental health consultation in early care and education settings, which has yielded promising results over the past decade.¹³ In home visiting, the mental health consultation is designed to build the capacity of the home visitors to recognize, interpret, and support the individual socioemotional needs of children and families in their care, especially when there are mental health concerns, and to support families in creating home environments that are positive climates for children's learning and growth.¹⁴ Mental health consultation can involve multiple types of support for home visitors, including consultation about the individual needs of children and families, professional development on mental health-related topics, and group and one-on-one reflective supervision. Reflective supervision provides home visitors with ongoing and regular opportunities for reflection to sort out and cope with strong feelings brought on by complex work with families.^{15–19} Reflective supervision also allows the home visitor to experience the same high-quality, supportive relationship that he or she is expected to provide for infants, toddlers, and families.¹⁵

Integrating mental health consultation into home visiting programs is based on a set of expectations about how programs can enhance their intended effects on parents and children served. Figure 1 provides a schema depicting several presumed pathways by which mental health consultation integrated

into home visiting programs might enhance outcomes for parents and children. The primary pathway is through the home visitors: mental health consultation provides information and support that are intended to equip home visitors with additional skills and to increase their effectiveness at helping families deal with parental or child mental health issues. This could improve not only children's socioemotional outcomes but, potentially, other outcomes, if mental or behavioral health issues have been barriers to other aspects of child learning and development. A second potential pathway to improved parent and child outcomes is through improved identification of behavioral health problems and facilitated referral to treatment or brief intervention, which can lead to increased capacity for positive parenting, healthy parent/child interactions, and healthy child functioning. A third pathway is through increased job satisfaction and reduced job stress for home visitors, which is hypothesized to increase effectiveness in working with the families they serve. A fourth pathway shown on the logic model is through a potential strengthening of the quality of implementation of the home visiting program (eg, stronger fidelity of implementation). If families receive help in addressing their mental health concerns, they may engage more fully with the home visitor who, in turn, may be better able to implement the planned strategies for improving family and child outcomes.

This developing approach in home visiting is particularly noteworthy in light of the rapid expansion in the number of families and children with access to home visitation services. Of the more than 4 million births in the United States each year, an estimated 400 000 infants and their families currently receive intensive home visitation services.²⁰

This number is expected to increase over the next 5 years, as states expand their evidence-based home visiting programs with funding provided by the Patient Protection and Affordable Care Act. This legislation provides \$1.5 billion in new federal dollars for the Maternal Infant and Early Childhood Home Visiting program.

MENTAL HEALTH CONSULTATION IN HOME VISITING PROGRAMS IN THE LINKING ACTIONS FOR UNMET NEEDS IN CHILDREN'S HEALTH PROJECT

Since 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been promoting behavioral health and prevention of future mental health problems in young children (prenatal to 8 years) and their families through its Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant program. Project LAUNCH provides funding to 35 states, tribal nations, and local communities to implement evidence-based programs that represent 5 broad prevention and promotion strategies: enhanced home visitation, family education and support, developmental screening and assessment, early childhood mental health consultation, and integration of behavioral health in primary care.

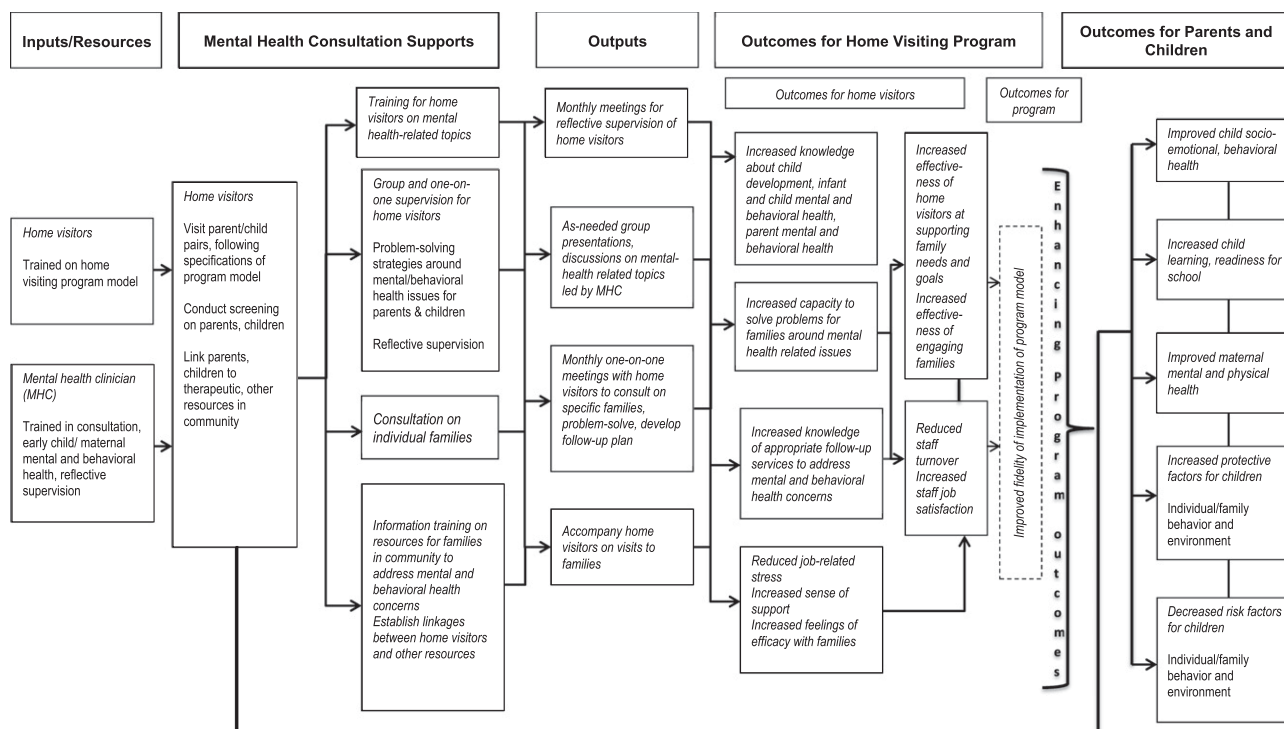
The mandate of Project LAUNCH has been an impetus for the LAUNCH communities to integrate physical and behavioral health services and supports for children and their families. One consequence has been that a growing number of Project LAUNCH grantees have opted to develop innovative models that integrate early childhood mental health consultation into existing home visitation services. This integrated model holds the promise of promoting parent and child behavioral health by enhancing the capacity of home visitors to identify and appropriately address the unmet mental

health needs of children and families. Additionally, these integration efforts are helping communities align with federal Project LAUNCH guidelines to enhance existing services, rather than supplant funds, and, in the case of the new federal home visiting program, Maternal Infant and Early Childhood Home Visiting, grantees are charged with supporting efforts to meet the benchmarks for high-quality implementation.

Project LAUNCH grantees are also implementing mental health consultation in primary care settings. Here, the motivation is the same: to give the primary care providers who are caring for young children and families with mental or behavioral health concerns access to trained mental health consultants. These consultants can provide screening, assessment, and consultation to the primary care providers about individual children and participate in developing a referral plan for appropriate services.

PROJECT LAUNCH HOME VISITING MODELS AND THE RISK PROFILE OF FAMILIES IN HOME VISITING PROGRAMS

Among the Project LAUNCH grantees funded between 2009 and 2011, 8 are implementing early childhood mental health consultation within 12 home visiting programs. Table 1 describes the program objectives, eligibility criteria, and staffing for these 12 programs. Data collected by grantees on the families who participated in the home visiting programs show that families experience multiple stresses that pose risks to children. On average, most mothers in the home visiting programs are single (63%) and lack a high school education (55%); in addition, 41% of the mothers are unemployed and 46% are teens. Forty-four percent of the mothers experience at least 3 of

**FIGURE 1**

Integration of mental health consultation into home visiting: presumed pathways for achieving outcomes for parents and children.

above risk factors. In terms of psychosocial risks, 16% of the families are identified as having someone in the household with mental illness, and 11% report that someone in the family is the victim of domestic abuse.

Features of Mental Health Consultation in Project LAUNCH-Supported Home Visiting Programs.

The 8 Project LAUNCH sites are implementing multiple types of mental health consultation activities in their home visiting programs, some that involve support to the home visiting staff and others that involve direct work with families. As shown in Table 2, in all sites the consultants provide reflective supervision, both one-on-one and to home visiting staff as a group.

A second type of support provided by the mental health consultant is collaboration with home visitors related to concerns about a specific child or family,

often referred to as child/family the above consultation.¹⁵ This involves working with home visitors to help them develop strategies to assist families that do not meet criteria for immediate crisis intervention but whose well-being is of concern.

A third common type of support is the consultant providing information and training to home visitors on mental health topics. For example, as reported by Project LAUNCH sites, mental health consultants have provided training to home visitors on strategies for managing their own stress and trauma, strategies for identifying mental health issues in parents and children and referral resources in the community, the developmental importance of early mother-child attachment, and addressing attachment disorders. Project LAUNCH sites use different approaches to this collaboration, ranging from consultation with a home visitor by telephone, to individual discussions outside the home setting, to accompanying home

visitors on family visits. The following is an example of this type of support provided by one of the Project LAUNCH enhanced home visiting programs:

A home visitor was working with a pregnant mother facing many complex challenges, including anxiety, severe depression, and domestic violence in the home. The mother had 2 children living with her, ages 2 and 6, as well as a 9-year-old living in Mexico. Child Protective Services had opened an inquiry in the home because of concerns about abuse with the 6-year-old child, yet determined a formal case was not warranted, a cause of concern for the home visitor. Unsure of her options, the home visitor turned to the mental health consultant who helped her to reduce her anxiety, gain perspective, and focus on what they could accomplish with the family. Working together, they developed a plan of action, which included follow-up with Child Protective Services, as well as an array of referrals for additional services to provide

TABLE 1 Home Visiting Models Supported Within 8 Project LAUNCH Grantees Integrating Mental Health Consultation

Project LAUNCH Grantee	Name of Home Visiting Program/Model	Core Components of Home Visiting Program/Model	Eligibility Criteria Established by Home Visiting Program/Model	Ages of Children in Home Visiting Program/Model	Characteristics of Home Visitors
East Oakland, CA	Improving Pregnancy Outcomes Program (IPOP) (county public health department)	Medical case management Maternal and child health Developmental screening and referrals Child development	Low-income pregnant and parenting African American women, men, and their infants	Prenatal–2 y	Public health nurses; BA-level case managers, community health outreach workers
	Black Infant Health (BIH) (county public health department)		Low-income pregnant and parenting African American women, men, and infants ≤ 18 mo Medically or socially at-identified risk for poor maternal pregnancy outcomes	20 wk (10 prenatal and 10 postnatal)	
	Your Family Counts (county public health department)	Maternal and child health Developmental screening and referrals Child development		Prenatal–1 y	
Weld County, CO	Parents as Teachers (PAT) ^a (community behavioral health program)	Child development Child health and safety Developmental, hearing, vision and referrals Family resiliency and protective factors Community resources and support Parent-child relationship Strengthening family supports and connecting to community resources	Families/guardians with ≥ 1 risk factor: isolation, poverty; education of parent; language barriers; developmental delays; parent with mental health and/or developmental delay	Birth–5 y	Degreed professionals (BA or MA level)
New Britain, CT	Child FIRST	Infant/child health and nutrition Child safety	Families with young children who are at risk for developmental delays or emotional disturbance	0–6 y	Child FIRST Team = One BA Care Coordinator and one MA/Licensed Mental Health Clinician Public health nurses or MA level
Washington County, ME	Bridging Program (community collaborative)	Child growth and development Community resources and support	Women who have infants or young children with multiple needs and/or women with high-risk pregnancies. Child need include babies born preterm, infants treated for medical issues in the NICU, infants and young children with high risk factors or medical and developmental issues, as well as parents who need extra support to meet the needs of their child.	Prenatal–8 y Services provided until family is stabilized and then transferred to less-intensive home visiting program	
Santa Fe, NM	First Born Home Visiting Program (United Way of Santa Fe)	Maternal prenatal Postnatal maternal and child physical and mental health Infant growth and development (including bonding and attachment) Child safety Stimulating home environment Access to community resources and support	First-time parents	Prenatal–3 y; Families enroll prenatally and receive visits up to the child's third birthday	Clinically trained degreed and nondegreed professionals ^c

TABLE 1 Continued

Project LAUNCH Grantee	Name of Home Visiting Program/Model	Core Components of Home Visiting Program/Model	Eligibility Criteria Established by Home Visiting Program/Model	Ages of Children in Home Visiting Program/Model	Characteristics of Home Visitors
New York City, NY	Nurse-Family Partnership Program (NFP) ^a	Healthy pregnancies and infants Child health, development, and screening Family social support and economic self-sufficiency Parent-infant attachment Community resources and support Prevention of child abuse through improved parent-child relationship Family stability	First-time mother, 28 wk pregnant or less, low income	Prenatal–2 y Families have the opportunity to participate for 2+ y (until child's second birthday)	Public health nurses
Multnomah County, OR	Healthy Start–Healthy Families Oregon–Healthy Families America ^a	School readiness Healthy child development Improved birth outcomes Infant and child health	First-time mothers At least 2 risk factors, or depression or substance abuse	0–3 y Families typically participate for 6–12 mo	BA-level professionals
Milwaukee, WI	Empowering Families of Milwaukee—includes Healthy Families America, PAT ^a (city public health department)	Child Safety Child growth and development Family functioning Improved pregnancy and birth outcomes Child health and development	Mothers at risk for poor birth outcomes First-time pregnant teens and women <28 wk pregnant	Prenatal–age 3 Families enroll prenatally and receive visits until child's third birthday Prenatal–2 y Families enroll prenatally and receive visits until child's second birthday	Social worker (BSW/MSW) or community health worker and public health nurse team Public health nurses
	NFP ^a (city public health department)	Family economic self-sufficiency Parent involvement School readiness	Resident of Milwaukee	3–5 y Program operates for a school year (30 wk), and families can participate multiple times when child is between ages 3 and 5	Parents
	Home Instruction for Parents of Preschool Youngsters (HIPPY) ^a (COA ^b Youth and Family Centers ^a)				

BA, bachelor's degree; BSW, bachelor's degree in social work; MA, master's degree; MSW, master's degree in social work.

^a Evidence-based program model.^b COA (the Community Outing Association) is a nonprofit agency supporting social service and educational projects in Milwaukee.^c Program model specifies that home visitors are public health nurses, because there is a short supply of clinically trained staff in the county, in Santa Fe, the home visitors are a mix of bachelor's degree and non-BA staff with experience in social services.

TABLE 2 Features of Mental Health Consultation Activities Integrated in Project LAUNCH Home Visiting Programs

Project LAUNCH Grantee/Home Visiting Program/ Model	Qualifications of MHC(s)	Supports Provided by Early Childhood MHC Within Home Visitation Programs						
		Approach to Reflective Supervision ^a	Frequency of Meeting With Home Visitors for Reflective Supervision	Child/Family-Centered Consultation Activities ^b	Estimated No. of Families for Whom MHC Collaborated With Home Visitor	One-on-One Therapy for Client (Traditional Therapy)	Estimated % of Consultant Time in One-on-One Therapy (Past Year)	Workforce Development on Specific Birth-8 Child and Family Mental and Behavioral Health Topics
East Oakland, CA	Licensed, master's- level clinician	Group staff meetings and one-on-one consultation	Group sessions, on average, 6 times per month and has at least 6 individual consultations per month	One-on-one formal and informal case consultation and referrals Partner with providers to co-facilitate in client groups on mental health themes	2–3 families per month	Short-term, immediate, individual and group therapy ^d	20% of time	Educate providers on key mental health topics (eg, childhood trauma, building healthy relationships, domestic violence, depression, substance abuse, immigration, anxiety)
Weld County, CO	Licensed, master's- level clinician	Group staff meetings and one-on-one consultation	2–4 times per month	Yes	20	If needed ^c	10% of time	Yes
New Britain, CT	Licensed, master's- level clinician	Group staff meetings and one-on-one consultation	2–4 times per month	Yes	10	No	0	Yes
Washington County, ME	Licensed master's- level clinician	Group staff meetings and one-on-one consultation	Monthly individual and group supervision	By phone, on an as- needed basis	6 families per month	Not provided ^c	0	Driven by needs that arise as part of supervision
Santa Fe, NM	Licensed, master's- level clinician	Group staff meetings and one-on-one consultation as needed	Weekly individual supervision Weekly group supervision	Yes	Estimated 3–4 families per month	Not provided ^c	0	Two seminars
New York City, NY	Licensed, doctoral- level clinician	Group reflective supervision and didactic presentations on topics generated by the nurses.	2 times a month	Case consultation and reflective guidance to nurses about specific families in group reflective supervision, identification and referral	39 (may be duplicated across quarters)	Not provided ^c	0	Didactic training topics arise from group and have included toxic stress, maternal depression, toddlerhood, temperament, and defense mechanisms
Multnomah County, OR	Licensed, master's- level clinician	Group reflective supervision	In initial phase	Yes	150–160 in a year	Not provided ^c	0	PBIS ^e trainings focused on home visiting
Milwaukee, WI: Nurse- Family Partnership Program	Licensed master's- level clinician	Group staff meetings and one-on-one interactions	Monthly	Case reviews Telephone and E-mail support Collaborative home visits Referral sources provided	7	Not provided ^c	0	Introduction to MHC Motivational interviewing Compassion fatigue Boundary setting Home visiting supervisor engaged in reflective supervision training

TABLE 2 Continued

Project LAUNCH Grantee/Home Visiting Program/ Model	Qualifications of MHC(s)	Supports Provided by Early Childhood MHC Within Home Visitation Programs						
		Approach to Reflective Supervision ^a	Frequency of Meeting With Home Visitors for Reflective Supervision	Child/Family-Centered Consultation Activities ^b	Estimated No. of Families for Whom MHC Collaborated With Home Visitor	One-on-One Therapy for Client (Traditional Therapy)	Estimated % of Consultant Time in One-on-One Therapy (Past Year)	Workforce Development on Specific Birth-8 Child and Family Mental and Behavioral Health Topics
Milwaukee, WI: Empowering Families of Milwaukee: Healthy Families America, Parents as Teachers (PAT)	Licensed master's- level clinician	Group staff meetings and one-on-one interactions	Monthly	Provide support in addressing screening results Case reviews Telephone and E-mail support Collaborative home visits Referral sources provided	43	Not provided ^c	0	Introduction to MHC Motivational interviewing
								Compassion fatigue
HIPPY	Licensed master's- level clinician	Group staff meetings and one-on-one interactions	Monthly	Provide support in addressing screening results Case reviews Telephone and E-mail support Collaborative home visits Referral sources provided	19	Not provided ^c	0	Boundary setting
								Home visiting supervisor engaged in reflective supervision training Introduction to MHC Mandatory reporting

HIPPY, Home Instruction for Parents of Preschool Youngsters home visiting program model; MHC, mental health consultant.

^a Reflective supervision refers to the MHC working with home visitors to build capacity and problem-solving skills around family/child mental health concerns; although reflective supervision may involve discussion of specific families, the focus is less on problem solving about a particular family and more on the development of the home visitors' own skills and strategies for working with families to solve problems. It is intended to create an environment characterized by safety, calmness, and support, in which supervisor and supervisee explore the range of emotions (positive and negative) related to the families and issues the supervisee is managing. The role of the supervisor is to help the supervisee to answer his or her own questions, and to provide the support and knowledge necessary to guide decision making. In addition, the supervisor provides an empathetic, nonjudgmental ear to the supervisee. Working through complex emotions in a "safe place" allows the supervisee to manage the stress he or she experiences on the job.²¹

^b Collaboration with home visitors in working with individual families with family/child concerns. May accompany home visitors on visits to families (1–3 times/family), may jointly develop referral plan, based on information in consultation interview with family, child/parent screening. The MHC and home visitors share some level of responsibility for outcomes for family, but the MHC is not the primary clinician or therapist to family; the MHC has a more indirect role.

^c In most of the Project LAUNCH sites, the home visiting programs purposely do not refer families to the MHC for therapy, out of concern that this could alter the objective of maintaining the primary relationship between the family and the home visitor. Exceptions have been made, however, when the MHC has been able to forge a bridge to treatment through building trust during a brief intervention with a family that was reluctant to access traditional mental health services.

^d In this project, the MHC takes on the role of providing brief family therapy, motivated largely by the program's recognition of the nearly complete lack of mental health services in the community. Treatment includes dyadic work with new mothers with bonding difficulty with their infant related to previous trauma or depression; treatment of situational depression often rooted in previous trauma, issues of child abuse, or substance abuse; treatment of generalized anxiety often brought on by birth of the child and related to previous trauma or depression, and perceived lack of support; group therapy focused on psycho-educational core factors of resiliency, attachment, healing, healthy relationships, building a community of support, and how to protect themselves and their children.

^e PBIS = Positive Behavior Interventions and Supports, an approach that uses a tiered prevention framework for young children; based on a "teaching pyramid" represents a continuum of supports and services designed to promote socioemotional competence and address challenging behaviors in young children.

mental health, health, social, and medical supports to the family. Unfortunately, cases such as these are common and the mental health consultant plays a key role in supporting home visitors in addressing complex family situations (Shinkle J, East Oakland Project LAUNCH, unpublished observations, 2012).

EVALUATING INTEGRATION OF MENTAL HEALTH CONSULTATION IN HOME VISITING

Project LAUNCH has been a platform for innovative models of early childhood mental health consultation in home visiting. If this integrated model continues to develop as an approach in home visiting, the field will need additional research first on the implementation of the model, and, second, on its effects, to provide the evidence the field needs to build quality standards for this approach. Comprehensive implementation studies are needed to illuminate how mental health consultation can be integrated with different evidence-based home visiting models. Then, rigorous impact evaluations should be conducted on the value-added of integrating mental health consultation into home visiting for home visitors and the families and children they serve. One of the unanswered questions concerns the impact of mental health consultation on fidelity of implementation for evidence-based home visiting models: on the one hand, model developers have expressed concern that adding mental health consultants could detract from local efforts to adhere to the model specifications. On the other hand, as depicted in the logic model, mental health consultation could result in better adherence, through increased engagement of hard-to-reach clients, greater likelihood of delivering the intended content, and reductions in staff turnover.

Initial findings are promising. Some studies have reported evidence that

home visitors with access to a mental health consultant have decreased stress levels, lessened rates of “compassion fatigue,” and reported an increase in professional growth, compared with home visitors who do not have consultation.^{22–24} Furthermore, Boris and colleagues²⁵ showed excellent feasibility of augmenting nurse home visitors with a mental health consultant who assisted with issues related to postpartum depression, domestic violence, and the impact of these risk factors on maternal-child interaction. Ammerman and colleagues²⁶ have developed and implemented a model of home visitation for depressed mothers that includes home-based mental health clinicians working in collaboration with home visitors. This augmentation of home visitation has helped home visitors facilitate successful referrals, along with mothers’ active engagement with services.

Within Project LAUNCH, preliminary findings based on self-reports of home visitors are encouraging. As part of the local evaluations in each of the Project LAUNCH sites, home visitors are asked about changes in their knowledge and practice associated with Project LAUNCH-funded activities. Responses from home visitors in 6 programs in which mental health consultation had been in place for at least a year showed that nearly 90% of the home visitors reported change in their knowledge of children’s socioemotional and behavioral health and development, and of available options for follow-up services for children with behavioral health issues (Goodson, BD, Gwaltney, MK, Walker, DK. Cross-Site Evaluation of Project LAUNCH: Interim Findings. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services; in review). Additional qualitative data from these Project LAUNCH sites

support the notion that these changes in knowledge resulted from collaboration with the mental health consultants. In the words of 3 home visitors:

My mental health consultant has specialized knowledge and skills that I don’t have. She has helped me to see things that I didn’t pick up on. She really focuses on engagement of the family in the process. And those are specialized skills that, again, most teachers, nurses, even social workers aren’t taught to address—such as readiness for change and motivation and things that might be blocking a family’s engagement. I’m not diagnosing, but now I pick up on possible undiagnosed problems. [Home visitor, Project LAUNCH]

I am able to focus more on secure attachment, discipline, and toddler behavior than I was before I had help from a mental health consultant. My observational skills of parent/child interaction have improved. [Home visitor, Project LAUNCH]

With support from my mental health consultant, I now pay more attention to a family’s mental health issues. It makes working with families easier because the mental health consultant helps to destigmatize mental health needs. We are working more with families on mental health issues, and providing referrals (to mental health consultation, as well as other services). As a result of mental health consultation, I am more skilled at assessing needs and have new ways to see and understand the complexities of mental health and well-being in families. [Home visitor, Project LAUNCH]

RECOMMENDATIONS AND NEXT STEPS

Home visiting and pediatric practices share common goals and are serving the same clients at a critical time in the lives of young children and their families.²⁷ Families who are experiencing risk factors, especially maternal depression, can benefit from enhanced collaboration between their pediatricians and home visiting programs.⁵ In primary care practices that are conducting routine screening for maternal depression, home visiting programs, especially those with enhanced mental health consultation, can be an excellent place for ongoing support to families who

exhibit depressive symptoms. Mothers with depression and families dealing with toxic stressors may be unlikely on their own to follow through on health promotion and prevention suggestions provided by the pediatrician. However, by linking with home visiting programs, pediatric practices have access to home visitors who can reinforce guidance from pediatricians, prepare parents for an anticipated development, and facilitate a family's use of appropriate ancillary services.²⁸

Thus, home visiting programs that provide mental health consultation to home visitors represent a potential resource for pediatricians who themselves may not be able to meet the needs of the growing population of children and families with mental health issues. The existence of these enhanced home visiting programs may increase the pediatric community's ability to connect families with other public and private community services that are important for the overall health of the child and family and encourage partnerships with referral networks to access these resources for their patients. Home visitation informed by mental health consultation

can be an important piece of the medical home model for delivering primary care that is continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, regardless of their health needs.

Project LAUNCH, which has been a springboard for innovation in the integration of mental health consultation in home visiting programs as well as in primary care settings, may be a promising platform for future research. Studies are needed on partnership approaches between pediatric practices and home visiting programs that include mental health consultation and the effects of these partnerships on the prevalence of maternal depression and the healthy development of young children. The epidemic of mental health concerns in the nation makes it imperative that we determine service models that can be effective with the most vulnerable families in our communities.

ACKNOWLEDGMENTS

We acknowledge SAMHSA, which provides funding for the Project LAUNCH program and the Training and Techni-

cal Assistance Contract led by the Education Development Center, and the Office of Planning, Research and Evaluation within the Administration for Children and Families, which oversees the cross-site evaluation of Project LAUNCH, led by Abt Associates. We thank Jennifer Oppenheim, Project LAUNCH Coordinator at SAMHSA, Laura Hoard, Social Science Research Analyst at the Administration for Children and Families, and Deborah Klein Walker, Vice President at Abt Associates, for reviewing an early draft of this article. We also thank the 8 Project LAUNCH grantees highlighted in the article and their local evaluators for providing information about their home visiting programs that integrate mental health consultation. Specific acknowledgment goes to the evaluators, local project staff, and technical assistance specialist for the East Oakland, CA, Project LAUNCH site: Lisa Erickson, Jill Shinkle, and Gabriel Fain; and the project director and local evaluator for the Milwaukee, WI, Project LAUNCH site: Leah Jepson and Courtenay Kessler. Finally, we acknowledge Missy Robinson for her production assistance.

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Pediatrics 2013;132;S180

DOI: 10.1542/peds.2013-1021S

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